MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, April 26, 2002
9:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
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AUTRY O.V. "PETE" DeBUSK
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FLOYD D. LOOP, M.D.
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RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM: CMS's proposed prospective payment system for long-term care hospitals -- Sally Kaplan

DR. KAPLAN: CMS published its proposed rule for the new PPS for long term care hospitals on March 21st. They use the acronym LTCH for long term care hospitals so I'll use it too, particularly on the slides.

The Congress has required MedPAC to analyze and report on the proposed PPS for exempt hospitals, of which long term care hospitals are one category. As part of our general responsibilities we're required to analyze payment rules. We can formally comment on the proposed PPS if we determine that there are potential problems with the payment system. Comments are due by May 21, 2002.

During the first part of my presentation I'll focus on what these hospitals are and do, and the general features of the proposed PPS. During the rest I'll focus on four issues that raise concerns. At the end of my presentation you'll have the opportunity to discuss these potentially problematic issues and raise others. We plan to use a formal comment letter to HHS on the proposed PPS as part of our response to the congressional mandate.

Long term care hospitals are defined by an average length of stay greater than 25 days. These hospitals furnish acute care to patients who have multiple comorbidities. A number of these patients are ventilator dependent.

Thirty-eight percent of these facilities are in Massachusetts, Texas, and Louisiana, although only 10 percent of Medicare beneficiaries leave in those three states. There were 270 long term care hospitals in 2001. In general, these hospitals are very dependent on Medicare patients. For hospitals established after 1983 Medicare represents, on average, 74 to 80 percent of their discharges. Growth in the number of hospitals and spending has been rapid in the 1990s. The number of hospitals has more than doubled and spending almost quadrupled. About one-third of long term care hospitals are co-located in the same building or on the same campus as acute care hospitals.

The proposed PPS will change the definitions of long term care hospitals so that the average length of stay will be calculated for Medicare patients only. This provision helps to ensure that these hospitals treat beneficiaries that need acute long term care and cannot be treated in acute care hospitals. Almost 40 long term care hospitals have a Medicare average length of stay of less than 25 days.

The Congress mandated that the unit of payment be a discharge. CMS created boundaries so that it does not pay hospitals full DRG payments for less than a full course of

treatment, and pays more for extraordinarily costly patients. The acute care hospital DRGs are used to classify patients who stay more than seven days. The hospital-specific relative value method uses charges which are normalized within each hospital and then made comparable across hospitals. This method has the advantages of simplicity and removes the bias introduced by hospitals using different levels of markups on charges.

The PPS will not adjust payments for either local input prices or for a disproportionate share of low income patients. Finally, the PPS will be phased in over five years.

For long term care hospitals case-mix adjusted per-discharge payments will range from $14,500 to almost $89,000 per case. CMS found that about half of patients stay less than two-thirds of a 25-day length of stay. Twenty percent of patients stay seven or fewer days.

If hospitals were paid a full discharge payment for short stays they would be paid well above their costs. As a result, CMS established two short stay policies which are shown in that chart on the screen. One for very short stays is for patients that stay one to seven days. These cases will be put into one of two special groups, one for psychiatric cases and one for non-psychiatric cases. Hospitals will be paid a special per diem rate for each day that these cases stay. The purpose of the very short stay policy is to discourage long term care hospitals from treating Medicare patient that do not require more costly resources and who reasonably can be treated in acute care hospitals.

The other short stay policy is for patients that stay eight days to two-thirds of the average length of stay for the DRG. These cases are classified into the DRGs and hospitals are paid the least of three rates, 150 percent of the DRG per-diem rate times the number of days, 150 percent of the per-diem cost times the number of days, or the DRG per-discharge payment. For patients who stay more than two-thirds of the average length of stay for the DRG long term care hospitals will be paid the full DRG per-discharge payment.

Now we're going to talk about our concerns. The first concern is about very short stays. We actually have two concerns about the very short stay policy. First, patients who die within seven days of admission to a long term care hospital are included in the short stay but they cost more than twice as much as those who don't die and have the same length of stay.

Second, the cliff between payments when a patient stays for seven days or eight days is huge. I've chosen two DRGs to illustrate the cliff on the screen and in your handouts. The DRG with the lowest weight, number 430 for

psychoses, and the DRG with the highest weight, 483 for tracheotomy except for face, mouth, and neck principal diagnoses. For DRG 430 the difference between payment for a seven-day stay is almost $5,000 less than for eight days. For DRG 483 the difference is almost $16,000. These large differences create financial incentives for long term care hospitals to keep patients until the eighth day.

Our next concern is about the fact that there is no adjustment for local input prices. As you all know, PPS rates are generally adjusted by a wage index to account for differences in local input prices. Everything we know says costs vary with wage index. In this case, however, CMS found that those differences weren't detected in the data.

We investigated two reasons why differences might not be significant. First, we investigated whether hospitals with high case-mix indexes have high wage indexes, which would mean that these indexes would be highly correlated. We found that the correlation coefficient is low: less than .12.

We also investigated whether the wage index varies by long term care hospital location. The X axis on this figure is the location of each long term care hospital that existed in the year 2000. As you can see on this slide, cost of living does vary in those places where long term care hospitals are located. If CMS doesn't adjust rates for local input prices hospitals with low wages may be overpaid, and those with high wages may be underpaid. If CMS does adjust by wage index exactly the opposite error may result. Because there is a concern about the quality of data it may be more prudent to use a wage index.

Our next concern is about the fact that there is no DSH adjustment. There are two rationales for DSH. One is to improve payment accuracy because low income patients are more costly. The other is to offset hospital's revenue losses due to uncompensated care. CMS only believes in the first reason. They found that DSH does not improve payment accuracy for this PPS. We, however, have concerns about beneficiaries' access to care. Without a DSH adjustment, low income patients may have difficulty accessing care in long term care hospitals.

This is another concern. Seventy percent of long term care hospital patients are transferred from acute care hospitals. These are not the transfers affected by these policies. Almost one-third of long term care hospitals are co-located in acute care hospitals, even in the same building or on the same campus. We can think about onsite transfers as round-trips from the onsite long term care hospital to the onsite acute care hospital and back again, or from the long term care hospital to an onsite SNF, rehab, or psych unit and back again.

CMS has concerns about extra payments that onsite

long term care hospitals can generate by round-trips and proposes limits on the proportion of round-trips onsite long term care hospitals can have without changes in payment. This policy, however, is not clinically based. It's based on the facility with no distinction in length of stay. In addition, the policy is based on a ratio of round-trips to discharges in real time, although the numerator and denominator can change daily. A better policy might be to have the QIOs monitor round-trips to determine if they are clinically appropriate.

This slide summarizes the crux of what the comment letter will say, we think. We don't have a lot of information so we've decided to raise issues about our concerns. We will distribute the letter to you by e-mail.

So the letter would express concerns about the very short stay policy, both the deaths and the cliff. It would express concern about the no wage index, and would express concerns about no DSH. We would state that instead of an onsite transfer policy CMS should use the QIOs, which were formerly the PROs, to monitor appropriateness of patients for long term care hospitals in general and onsite readmissions in particular, or onsite round-trips in particular. And because many design decisions are based on poor data that they should revisit the PPS design in two years.

MR. HACKBARTH: Questions?

DR. LOOP: I agree with your concerns. The question is, if a patient exhausts their Part A benefits and reverts to Medicaid, is that not considered part of the length of stay then if they change their status?

DR. KAPLAN: My reading of the rule is that when considering the length of stay they're considering the entire Medicare, or the length of stay. They aren't just concerned about covered days. What you're talking about is when covered days expire. But from what I'm able to read in the rule, and it's something that CMS needs to clarify, is that it would be based on the average length of stay, not the covered days.

DR. NELSON: Sally, is the proportion of the total hospital census that is Medicare comparable to acute care hospitals or are they skewed either toward greater percentage Medicare or a lesser percentage Medicare?

DR. KAPLAN: I believe, and I think Jesse or Jack can -- it's much higher, but I think the acute care hospital is about 40 percent Medicare. The hospitals that were established prior to 1983 have about 55 percent Medicare patients, but those established after 1983 average 75 to 80 percent.

DR. NELSON: The second question is -- this relates to the DSH thing -- do most of them have access to capital when they need it, or is there a problem within that

industry with access to capital?

DR. KAPLAN: I'm really not aware of what their ability to access capital is. There's some big chains that are on the New York Stock Exchange and my understanding is they've done very well so I would assume that they have access to capital. The non-profits generally were established prior to 1983. I don't know what their situation is. And then some of them are not chains as well.

DR. NELSON: Thank you.

DR. REISCHAUER: I find this whole segment of the health care industry a little unsettling. You were saying that the judgment of whether the new system is okay is payment accuracy. I'm wondering how that's measured. It's cost versus payments under the new system, but costs presumably include a lot of costs that may be there because these are entities or some of these are entities which were stimulated by a desire to get around the PPS system, especially during the last decade. So they might have a lot of costs imbedded in them that really should be spread more evenly across the larger economic enterprise which we're talking about.

By building a system that makes everybody more or less whole what we're doing is, in a sense, confirming what was an attempt to circumvent the old system. So should we have this worry about payment accuracy?

DR. KAPLAN: I think that CMS primarily most of their decisions that they made, design decisions on this PPS were made on the basis of accuracy. How they defined accuracy was the amount of variance explained in the cost by the various variables.

DR. REISCHAUER: But it's the old costs.

DR. KAPLAN: Right, the old costs. And of course, did not take into consideration that some of these hospitals are very old and came in under TEFRA under very different cost levels than the newer hospitals.

As far as hospitals, particularly hospitals within hospitals who benefit from being co-located in an acute care hospital and may have been established to get around the acute care PPS, we're hoping to be able to look at this issue next year to be able to determine whether those people really do have different costs, and whether the hospitals that they're co-located in have different costs.

DR. REISCHAUER: Given the very strange distribution of these entities it's clear that a lot of Medicare patients who need long term care are served in acute care hospitals and they've become the outlier probably in that system. One wonders what, under the acute care system, the outlier payment is relative to what you would get for the same kind of activity in a long term care hospital under their new payment policy. You want some kind of evenness to this system.

MS. RAPHAEL: The other question I had, Sally, was trying to place long term care hospitals in the constellation of post-acute, in terms of thinking about DSH and access problems. I don't have a good sense of what kind of patients are appropriate or tend to land in long term care hospitals versus rehab facilities versus SNFs or home health care. Do we have any sense of that?

DR. KAPLAN: The Urban Institute did a really good study on the difference between long term care hospitals -- not home health, because it's unlikely that these people could be cared for at home. Theoretically they have to need hospital care to be in a long term care hospital, theoretically. Although I'm not sure that the PROs are really monitoring them, but theoretically they do. They're much sicker than patients who would be in SNFs, and rehab particularly.

The Urban Institute generally found that a lot of these cases are rehab cases. In fact some of these hospitals, as I told you in the mailing material, do specialize in rehab. But that these are not the same types of patients that one would find in a rehab hospital. They couldn't -- they're too sick to be able to sustain the three hours of therapy per day and don't have -- they improve but they don't -- have the capacity to benefit from the rehab but certainly not to the extent that they would in the rehab hospitals.

So I really envision these people when I think about post-acute care as really being the sickest people with probably the worst prognosis of the people in post-acute care. They're more acutely ill than the people who would be in a SNF, even those that are in hospital-based SNFs. And have a pretty high death rate also. I can get you all that information but not -- unfortunately we're not meeting again until the retreat.

I guess my question would be, what do we say about the payment system in the comment letter?

MR. HACKBARTH: Can we go back to Bob's comment? What you say makes sense to me. This is an unusual institution in that it's so clustered geographically. But if you're CMS you're in a bit of a box. The statute does provide for this different class and legitimizes it in that sense. If you're CMS and writing a reg and you make all the points that you just made, Bob, and say, we're going to take money out of the system through the reg-writing process, that may cause some problems to say the least.

So if in fact what we're going to do is say, no, this isn't an appropriate expenditure of Medicare funds, this sort of class just doesn't fit right and we need to go back and revisit that, I'm not sure that that's a regulatory sort of activity. So what I'm trying to get a feel for, Bob, is if we adopt your point of view, how do we couch it

in a letter commenting on this regulation? What exactly should we say? What is the policy direction that we're articulating?

DR. REISCHAUER: I think this is a much bigger issue and certainly one that we don't have the information to resolve whether my concerns are legitimate or not. So what this would suggest is that, at the most we just say that we would like the payment policy to be one in which there weren't huge discrepancies between the treatment of these individuals in acute care facility versus this long term care facility unless there are clear justifications. Just to give a little flexibility, but I wouldn't do anything more than that. We're being asked to actually answer a relatively narrow kind of question that assumes away all of my concerns.

MS. BURKE: But if I might, it's suggested in the comment we suggest or review within a certain time frame, within two years. I absolutely agree with Bob. I think there are a series of underlying questions about -- there is this odd geographic location issue and presumably the rest of the country somehow manages to struggle along. So one might want, going forward, to have a better understanding of what issues there are in terms of the equity of the treatment of patients and the costs that people are incurring. I mean, they can't all live in Texas. There has to be people in California with a similar problem.

But it would seem to me in the context of looking at this, knowing that they have the short term problem, that the longer term is to look at these underlying questions and be prepared to come back within a time frame, perhaps in a year, which would allow you then to make an adjustment in anticipation of the following year; some time frame where you could adjust, but get them through this period. But it seems to me those questions are questions that ought to be addressed over the long term.

I think what Sally suggested, and I think the points you've raised, Sally, in terms of the other issues are perfectly legitimate and absolutely comfortable raising each of those as questions about this absolute structure. But I think the underlying questions are ones that bear some study and I think it's not inappropriate for us to say that in the context of going forward.

DR. KAPLAN: And you want us to say that CMS should do this study.

MR. MULLER: This is built on Bob and Sheila's comments. I think the geographic incidence obviously has caused everybody to say there's something going on here that's independent of the patient's condition. So this is more a function -- now I'm just guessing, whether there are state or county institutions that they converted towards this in those states. I know from my own experience that

these kind of patients are now in acute hospitals as well, and in fact 483 is probably the biggest outlier that most hospitals have in terms of -- I mean the DRG that kicks into outlier status.

So I think looking at information on the patients in the acute setting vis-a-vis the setting is something we should suggest they look at very carefully, because my guess too is that the incidence of these facilities is more a function of institutional characteristics of the state rather than characteristics of the patients. So therefore, exactly -- and whether one wants to get it therefore into -- I mean, even the issues that you appropriately suggest on disproportionate share, for example, and so forth, may not come out as smoothly given that it's so concentrated in three states, as it would be if it was across the 50 states.

MR. HACKBARTH: I think that's true. The disproportionate share adjustment in our view of the world is a broad public policy to provide some support for indigent care. Given that this is clustered in three or four states it does look odd.

DR. LOOP: I think that geographic dispersion is biasing our feelings here. I believe that the long term care facility does really add a lot of value to the health system, if it's done right. I'm familiar with the one that we're affiliated with and I don't know -- there's no profit related to that. It really takes the chronically ill people out of the hospital. More than 30 percent of them have long term respiratory needs.

I think this is sort of a cookie-cutter approach to these patients who are just deadly ill. They have a huge number of comorbidities. There's even some pediatric and psychiatry patients mixed in with all of that.

So I think there's some perverse incentives in here too, many of which Sally mentioned. But if you are in a long term care facility and have to be transferred to an acute care hospital, and then after treatment are transferred back to the long term care facility, the long term care hospital only gets reimbursed for the second admission, which is kind of strange. It would be a perverse incentive not to send people to the acute care hospital when they're sick, just like the cliff between seven and eight days is a perverse incentive.

So I think those things have to be cleaned up and her letter will say that. But I'd like to go on the record as saying that the long term care hospital in my experience adds a lot of value to a health system.

MR. HACKBARTH: From my perspective, the point is not to denigrate what they're doing and say that it's not valuable. But having said that, one of our cardinal payment policy principles is that you need to look at payment across different types of settings, so that if similar patients are

handled in different ways in different states, different communities, you don't have gross disparities in the payment across communities, or for that matter within one community. So I think Bob's point about looking at reference points other than the historic cost of these institutions is a legitimate thing to do, without denigrating the work that's being done.

DR. NELSON: Not to denigrate, but they've quadrupled in spending. What percentage are investor-owned, Sally, roughly? The majority?

DR. KAPLAN: I can't remember offhand, to tell you the truth, but there are two big chains involved. Vencor, or what used to be Vencor, which is now Kindred, which is primarily ventilator dependent hospitals, and another chain.

DR. NELSON: I think the important contribution is to refine the PPS as accurately as possible. Remove -- if it's a really sweet deal, make it a deal that's no sweeter than the rest of the hospitals.

DR. REISCHAUER: Sally, besides expressing our concern about the seven to eight-day cliff are we going to suggest alternatives? Because just looking at this it strikes me that it's strange to have a seven-day limit for everything. That it should be half of the average length of stay for that DRG or something like that, which would then, in a way, reflected the distribution of lengths of stay for each DRG and would reduce this kind of problem. Because when you look at that number for tracheotomies you go, good Lord, of course you keep the person the eighth day. But it might turn out that 99.9 percent of tracheotomy patients are in the hospital 23 days or more, so this isn't something that we should spend sleepless nights worrying about.

Are we just going to express concern, or are we going to suggest some alternatives was my question?

DR. KAPLAN: I think that our alternative was to smooth -- to get rid of the huge cliff.

DR. REISCHAUER: How?

DR. KAPLAN: I don't know.

DR. REISCHAUER: I was suggesting a way to do that. There must be hundreds of --

DR. KAPLAN: Right, which would be over half the average length of stay.

DR. ROSS: One of the ways to do it is to go to a per-diem instead of a per-discharge, but I don't think we're ready to make any recommendation along those lines. We don't know enough about it at this point.

MS. BURKE: You could do it by proportion, scale it up. The farther out they go, the closer you get to full weight.

MR. MULLER: Sally, what do we know about the cost in these facilities vis-a-vis the comparable cost in acute facilities? I mean in those other 47 states.

DR. KAPLAN: First of all, they aren't quite that concentrated. Unfortunately, I didn't bring the map that David very nicely made for me which showed where they're located. But there is a concentration in those three states, but they are a little more dispersed than that.

MR. MULLER: I understand.

DR. KAPLAN: We haven't done a comparison of what it costs in an acute care hospital. There's been a comparison done as to how many of these folks are outliers before they go into the long term care hospital. I was kind of surprised that they actually weren't as heavily tilted towards the outliers in the acute care hospitals. It sounds like the acute care hospitals pretty much shift them before they become outliers.

I think this is all work that if you're interested in we could do next year, or we could ask CMS to do this type of work. I think it would give a lot more information. I don't think this work can be done before the PPS goes -- before we have to comment and certainly not before the payment system is implemented in October.

MR. MULLER: If you go with Floyd's and Bob's comments, I think the rational place these facilities have is in fact taking care of these patients and then having acute hospitals -- you don't want these staffed up to acute hospital staffing standards. So the opportunity to have an acute hospital, as Floyd suggests, where they go back when they need acute care in a seamless way is a very efficient way of doing that.

I know my own experience, such as Floyd's as well is that you can staff these at a much lower level than an acute setting. When you have a patient that you know is going to be in for many, many days or often months on end it becomes a very cost effective way of treating these patients, as long as you have the acute backup. Therefore, being able to go back and forth between the acute and the long term care setting without having steps or cliffs and so forth is a very appropriate way of trying to match the payment policy with the clinical policy.

So I think having some sense therefore of what the costs are, my guess is that in a lot of these settings that the institutions haven't been created. I'm familiar with one of these states and having run these programs in one of these states, these are basically the old TB places that you converted into these long term care hospitals. So if you have some extra TB facilities in your state that are being shut down you convert them into this. So this happened just in one of these states.

MR. HACKBARTH: So what we're talking about here is basically a two-part letter I think. One part addresses the specific issues raised by the proposed regulation within its frame of reference. Then the second is actually

probably more addressed to the Congress than it is to CMS raising some more basic questions about how these institutions and the associated payment policies fit with the larger scheme of things. There is work to be done, analysis to be done to answer those questions.

DR. STOWERS: I just want to make a comment. I agree with everything about the cliff and all of that kind of thing. But as we talk about the distribution, I know we have one in Oklahoma which is related to a hospital that closed. It serves a good purpose there.

We have some past work on uneven distribution with Medicare+Choice, which is concentrated in a few states but yet is scattered out across the country. I'm wondering if it wouldn't be a good idea, like we looked at the market and what supported that in certain parts of the country and other -- that before we move too quickly on this distribution thing, if we don't approach is somewhat from the same angle of looking at market and why it is happening in those states before we would proceed too far.

So I know that some hospitals in some areas are closed hospitals and other reasons -- and those that I've seen I agree with that entirely. That may be occurring more in certain states and parts of the country because of other market factors. So I just think we need to look into that a little deeper.

MR. HACKBARTH: So if we couch this not as answers but questions that occur to us as we look at this particular type of institution. No conclusions at this point.

DR. STOWERS: Yes, I think we'd be helping all parties concerned to approach it from that angle on this distribution thing and look into it a little deeper if we're going to go ahead and proceed with this.

MS. BURKE: Glenn, just one side note. Frankly, Ray, I care less about where they are than the equity issues that Bob raises. I don't care if they're all in one state. The question is, how are we treating similarly disposed patients in different settings? So I don't argue with your point, there are clearly market reasons they have occurred, in part the pre-'83s my guess are some of these guys that were the old TB hospitals. But I'm less concerned about that, differently than I would be in terms of Medicare+Choice, than I am about what is the underlying question of similar disposed patients.

DR. STOWERS: I was just using Medicare+Choice as an example that we do treat patients differently in some metropolitan areas than in other areas because of a market difference. But I agree that in the end the payment ought to be somewhat equitable for what we're doing.

DR. REISCHAUER: We do, but people are complaining about it.

DR. STOWERS: I agree.

DR. LOOP: There are also some recent trends in hospitals that weigh into this. Volume of admissions are way up. There's a big problem with capacity management. Hospitals are really not designed either in structure or the labor issues today for long term care. A good long term care hospital adds a lot, which I said earlier. But if we were talking 10 years ago, there was not the same capacity issues in hospitals than there is today.

MR. HACKBARTH: Others?

DR. NELSON: In going through the numbers of cases that have been submitted on claims, the diagnoses, acute psychiatric diagnoses, the top half-dozen are respiratory failure requiring a ventilator, rehab, skin ulcers, stroke, congestive heart failure, renal failure, septicemia. So it doesn't read unlike the kinds of diagnoses that would be within the outlier population in a general hospital.

MR. HACKBARTH: Sally, do you have what you need?

DR. KAPLAN: I think so. Thank you.